Exhibit 19

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

IMPORTANT: USE THIS FORM ONLY WHEN THE CLAIMANT BECOMES SICK OR DISABLED WHILE EMPLOYED OR BECOMES SICK OR DISABLED WITHIN FOUR (4) WEEKS AFTER TERMINATION OF EMPLOYMENT. OTHERWISE USE GREEN CLAIM FORM DB-300.

PART B - HEALTH CARE PROVIDER'S STATEMENT (Please Print or Type)

THE HEALTH CARE PROVIDER'S STATEMENT MUST BE FILLED IN COMPLETELY AND THE FORM MAILED TO THE INSURANCE CARRIER OR SELF-INSURED EMPLOYER, OR RETURNED TO THE CLAIMANT WITHIN SEVEN DAYS OF THE RECEIPT OF THE FORM. For item 7d, give approximate date. Make some estimate. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date under "Remarks".

1. Claimant's Name Francesco Gallo 2. Age 57 3. Sex ☒ Male ☐ Female
4. Diagnosis/Analysis Cortico basal degeneration Diagnosis Code 333.0
a. Claimant's Symptoms Inability to use (R) upper extremity
b. Objective Findings weakness, rigidity, marked ... [illegible]
5. Claimant Hospitalized? ☐ Yes ☒ No From .... To ....
6. Operation Indicated? ☐ Yes ☒ No a. Type .... b. Date ....
7. Enter Dates for the Following:

	Month	Day	Year
a. Date of your first treatment for this disability	04	05	05
b. Date of your most recent treatment for this disability	07	18	06
c. Date claimant was unable to work because of this disability	05	28	06
d. Date claimant will be able to perform usual work	N/A		permanent

(Even if considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.)

8. In your opinion, is this disability the result of injury arising out of and in the course of employment or occupational disease? ☐ Yes ☒ No
If yes, has form C-4 been filed with the Workers' Compensation Board? ☐ Yes ☐ No
Remarks (attach additional sheet, if necessary) .... (If disability is pregnancy related, please enter estimated delivery date.)

I affirm that I am a	☐ Chiropractor ☐ Dentist	☒ Physician ☐ Podiatrist	☐ Psychologist ☐ Nurse-Midwife	Licensed in the State of: New York	License Number: 098147

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

Health Care Provider's Signature [signature] Date 7/18/06
Health Care Provider's Name (Please Print) John J. Caronna Tel.No. 212-746-2304
Office Address 520 E 70 St NY NY 10021
Number Street City/Town State Zip Code

EMPLOYER'S STATEMENT

Employer's Name ALITALIA
Employee's Date of Birth 12/26/48 Policy # 0566582 Div. # ....
Is this claimant a N.Y. employee? ☒ Yes ☐ No ☒ Full Time ☐ Part Time Effective Date of Coverage 1/1/02
Date of Employment 9/30/1968 .... % paid by Employee
Normal work week (check boxes to show usual days worked) .... % paid by Employer
Date Employee last worked 5/26/06 Number of Hours 8 S ☐ M ☒ T ☒ W ☒ T ☒ F ☒ S ☐
Date Employee wages ceased 5/26/2006
Date Employee returned to work N/A
Has Employment terminated? ☐ Yes ☒ No
If so, date of termination ....
Was Employee laid off or was layoff contemplated prior to disability? ☐ Yes ☒ No
If so, give day of layoff ....
Were wages continued during disability? ☒ Yes ☐ No
If yes, does the Employer request reimbursement? ☒ Yes ☐ No

Employer Reimbursement Request: If Yes, the Employer agrees to indemnify UnumProvident Corporation and hold the Company, its directors, officers, employees and agents harmless against any claim, loss, liability, suit or judgment (including attorneys' fees and cost of defense or investigation related thereto) that arises as a result of the Employer's obligation to pay benefits under the Policy on behalf of the Company. In addition, the Employer shall indemnify UnumProvident Corporation against any claim by an insured for benefits that have been paid by the Employer and reimbursed by the Company.

Earnings 8 weeks prior to disability

Week Ending	Mo.	Day	Yr.	No. Days Worked	Amount
1	4	9	06	5	[illegible]
2	4	16	06	5	[illegible]
3	4	23	06	5	398.3?
4	4	30	06	5	[illegible]
5	5	7	06	5	398.3?
6	5	14	06	5	398.3?
7	5	21	06	5	[illegible]
8	5	28	06	5	398.37

Was Employee on the job when disability occurred? ☒ Yes ☐ No
Has claim been filed for Workmen's Compensation? ☐ Yes ☒ No
Is Employee member of a union that provides payment of weekly cash benefits? ☐ Yes ☒ No
If yes, give name and address of union ....
Signed [signature] Employer ALITALIA
Telephone Number (212) 903-3558 Date 11/9/06

THE WORKER'S COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.

DB-450 Reverse (11-98)

Mail To: Unum Life Insurance Company of America, Portland Customer Care Center, P.O. Box 9000 Portland, ME 04104-5058, Phone: 800-858-6843, Fax: 800-447-2498

RECEIVED VIA USPS PORTLAND INTAKE CENTER

PERSONNEL ADMINISTRATION

UNUMPROVIDENT

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

CLAIMANT: READ THE FOLLOWING INSTRUCTIONS CAREFULLY

1. USE THIS FORM IF YOU BECOME SICK OR DISABLED WHILE EMPLOYED OR IF YOU BECOME SICK OR DISABLED WITHIN FOUR (4) WEEKS AFTER TERMINATION OF EMPLOYMENT. USE GREEN CLAIM FORM DB-300 IF YOU BECOME SICK OR DISABLED AFTER HAVING BEEN UNEMPLOYED MORE THAN FOUR (4) WEEKS.
2. YOU MUST COMPLETE ALL ITEMS OF PART A - THE "CLAIMANT'S STATEMENT". BE ACCURATE. CHECK ALL DATES.
3. BE SURE TO DATE AND SIGN YOUR CLAIM (SEE ITEM 12). IF YOU CANNOT SIGN THIS CLAIM FORM, YOUR REPRESENTATIVE MAY SIGN IT IN YOUR BEHALF. IN THAT EVENT, THE NAME, ADDRESS AND REPRESENTATIVE'S RELATIONSHIP TO YOU SHOULD BE NOTED UNDER THE SIGNATURE.
4. DO NOT MAIL THIS CLAIM UNLESS YOUR HEALTH CARE PROVIDER COMPLETES AND SIGNS PART B - THE "HEALTH CARE PROVIDER'S STATEMENT."
5. YOUR COMPLETED CLAIM SHOULD BE MAILED WITHIN THIRTY (30) DAYS AFTER YOU BECOME SICK OR DISABLED TO YOUR LAST EMPLOYER OR YOUR LAST EMPLOYER'S INSURANCE COMPANY.
6. MAKE A COPY OF THIS COMPLETED FORM FOR YOUR RECORDS BEFORE YOU SUBMIT IT.

PART A - CLAIMANT'S STATEMENT (Please Print or Type) ANSWER ALL QUESTIONS

1. My name is FRANCESCO (First) GALLO (Last) — Social Security Number [1][0][9] [4][2] [3][0][2][3]
2. Address 300 EAST 54th ST. APT. 32ME NEW YORK NY 10022 (Street, City, State, Zip)
3. Tel. No. 212-751-7380 4. My age is 59 5. Married (Check one) ☑ Yes ☐ No
6. My disability is (If injury, also state how, when and where it occurred) PARALYSIS
7. I became disabled on 05 / 06 / 006 a. I worked on that day ☑ Yes ☐ No
   b. I have since worked for wages or profit. ☐ Yes ☒ No If "Yes", give dates
8. Give name of last employer. If more than one employer during the last eight (8) weeks, name all employers.

EMPLOYERS			DATES OF EMPLOYMENT		AVERAGE WEEKLY WAGES (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
BUSINESS NAME	BUSINESS ADDRESS	TELEPHONE NO.	FROM Mo. Day Yr.	THROUGH Mo. Day Yr.	
[illegible]		212-[illegible]3428	09 30 1969	05 18 06	$ 4,500.00

9. My job is or was (Occupation) (Name of Union and Local Number, if Member)
10. For the period of disability covered by this claim
   a. Are you receiving wages, salary or separation pay: ☐ Yes ☒ No
   b. Are you receiving or claiming:
      (1) Workers' compensation for work-connected disability ☐ Yes ☒ No
      (2) Unemployment Insurance Benefits ☐ Yes ☒ No
      (3) Damages for personal injury ☐ Yes ☒ No
      (4) Benefits under the Federal Social Security Act for long-term disability ☐ Yes ☒ No

   IF "YES" IS CHECKED IN ANY OF THE ITEMS IN 10a OR 10b, COMPLETE THE FOLLOWING:
   I have ☐ received ☐ claimed from (Source) for the period (Date) to (Date)
   Jullu(x [illegible]
11. I have received disability benefits for another period or periods of disability within the 52 weeks immediately before my present disability began ☐ Yes ☒ No
   If "Yes", fill in the following: I have been paid by From (Date) To (Date)
12. I have read the instructions above. I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled; and that the foregoing statements, including any accompanying statements, are to the best of my knowledge true and complete.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

Claim signed on 7/18/006 [signature] (Claimant's Signature)

If signed by other than claimant, print below: name, address, and relationship of representative.

IF YOU HAVE ANY QUESTIONS ABOUT CLAIMING DISABILITY BENEFITS, CONTACT THE NEAREST OFFICE OF THE NYS WORKERS' COMPENSATION BOARD, OR WRITE TO: WORKERS' COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY-MENANDS, ALBANY, NY 12241-0005

SI TIENE DUDAS RELACIONADAS CON LA RECLAMACION DE BENEFICIOS POR INCAPACIDAD, COMUNIQUESE CON LA OFICINA MAS CERCANA DE LA JUNTA DE COMPENSACION OBRERA DE NUEVA YORK, O ESCRIBA AL: WORKERS' COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY-MENANDS, ALBANY, NY 12241-0005

DB-450 (11-96)

HEALTH CARE PROVIDER MUST COMPLETE PART B ON REVERSE

OCT 13 2006
PERSONNEL ADMINISTRATION